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Statement of Purpose:
AIDS Treatment News reports on experimental and standard treatments, especially those available now. We interview physicians, scientists, other health professionals, and persons with AIDS or HIV; we also collect information from meetings and conferences, medical journals, and computer databases. Long-term survivors have usually tried many different treatments, and found combinations that work for them. *AIDS Treatment News* does not recommend particular therapies, but seeks to increase the options available.

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articles online as news happens.

"Shy" Study Suggests New Treatment Mechanism

by John S. James

A careful study of 54 asymptomatic, HIV-positive gay men, published December 15, 2003, in the journal *Biological Psychiatry* found that "socially inhibited" individuals had a viral load setpoint eight times higher than others -- and a much worse response to antiretroviral treatment as well, with only about one eighth of the viral load reduction of the other volunteers (all treated volunteers were starting HAART for the first time).(1) The study also showed that elevated activity of the autonomic nervous system explained most of this difference -- showing "the first clinical evidence that differential neuronal activity mediates relationships between psychological risk factors and infectious disease pathogenesis" (quotation from the abstract). Apparently socially inhibited persons have a higher baseline stress level, and control excess stress by limiting social interaction.

The authors note other studies showing that norepinephrine, which is released in response to stress, changes the function of cells in several ways that result in faster HIV replication. They note that naturally occurring differences in autonomic nervous system activity can be associated with up to a 100-fold difference in HIV viral load -- and suggest testing drugs that might become powerful adjunctive therapies, slowing HIV progression and

greatly improving antiretroviral treatment in many patients.

A recent article in *The Washington Post* discussed this work, and related work of other scientists.(2) For example, a link between depression and HIV progression may be mediated by different biochemical pathways -- opening doors to different treatments for depressed patients than for those with a high stress level.

Comment: Designing Clinical Trials

There are already approved drugs, widely used for other purposes, that can reduce some of the mechanisms that may be responsible for poor control of HIV and poor response to antiretrovirals in certain patients. But until recently, nobody had any reason to imagine using them as part of a strategy for reducing HIV viral load. (For example, beta-blockers are used to lower effects of norepinephrine. But the link with depression might lead to entirely different drug candidates, for to different patients.)

Once plausible drugs are identified, they could be tested relatively easily, because viral load is a continuous measurement that reaches a new setpoint fairly rapidly. For example, one might select patients who are poorly controlling HIV (so that they have a large scope for improvement), who meet other criteria such as social inhibition suggesting that the drug being tested might work particularly well (so that success is easy to see), and who also have a fairly stable viral load, either on treatment or off (so that changes can more easily be attributed to the drug being tested). These patients would be randomized to either take the drug immediately or wait a few weeks; in either case their viral load would be carefully monitored for several weeks or months. If the drug worked as hoped, there would be a large decrease in viral load without any other change in antiretroviral treatment. If this happened, the volunteers would be followed indefinitely to see if the treatment could be continued successfully. These trials would only require a few patients each. They could be designed, recruited, and conducted in months, not years.

It is likely that drug candidates can be found that are already widely available and well known in human use. Some of them may be inexpensive. Often manufacturers of non-HIV drugs do not want an HIV use discovered (because they fear that patients, or their family members or friends, will wrongly suspect that someone is secretly being treated for AIDS -- threatening a large market for a much smaller one). But if a drug is already in widespread use, the manufacturer's cooperation in researching it, while helpful, would not be necessary. The community will need to pay attention, however, and take initiative to make things happen. The system cannot be trusted to work by itself.

At a time when progress in conventional antiretroviral treatment has slowed, here is a wide-open area that, if it works, could rapidly lead to major treatment advances.

References

(1) Cole SW, Kemeny ME, Fahey JL, Zack JA, and Naliboff BD. Psychological risk factors for HIV pathogenesis: Mediation by the autonomic nervous system. *Biological Psychiatry.* December 15, 2003; volume 54, pages 1444-1456.

(2) "Stress Found to Weaken Resistance to Illness" by Shankar Vedantam, *Washington Post*, December 22, 2003, page A12.

Abbott Laboratories Increases Norvir Price Fivefold

by John S. James

In an entirely unexpected move on December 4, 2003, Abbott Laboratories increased the U.S. wholesale price of its 100-mg capsules of ritonavir (Norvir®), to five times what it had been the day before -- and increased the price of the liquid

formulation comparably. Norvir, originally approved in 1996 and with estimated sales of over $1.3 billion to date, is widely used in small doses to "boost" the effect of other protease inhibitors, and the new price will greatly increase the cost of several widely used treatments. The new price may be the largest overnight, unexpected price jump in history for a life-critical drug.

Abbott did not announce the increase except in a letter to wholesalers stating the new price (we learned about the change through emails from patients). After opposition from doctors' and other organizations, and stories in *The Wall Street Journal*, *Chicago Tribune* (Abbott is located outside Chicago), and other news media, Abbott sent a Dear Doctor letter to HIV physicians, saying that it had carefully planned the increases so that they would not block patients' access. It said it would provide the drug free to those who pay out of pocket (about 5% of patients using the drug, according to Abbott) regardless of their financial status -- and would not raise the price for ADAP or Medicaid until June 2005. [Note: It could not raise these government prices much until 2005 anyway, due to existing regulations and agreements]. For those paying through private insurance (about 40%), Abbott said it had contacted "many" health-insurance providers and found that they do not restrict HIV medications through a formulary, nor plan to increase co-pays or premiums. (Prices outside the U.S. are unchanged because of price controls in the major markets.)

In fact, patients are already changing their treatment (especially from full-dose Norvir), despite the risk of switching from a regimen they know is working for them to one they do not know (see "Price of AIDS Drug Soars Fivefold" in the *Seattle Times*, January 5, 2004). And another problem not visible right away is that some insurance companies keep raising premiums for those who need expensive care, eventually making the insurance prohibitive and abandoning these patients.

Abbott did not raise the price of the small ritonavir dose in Abbott's Kaletra product -- immediately putting competitors' protease inhibitors at a major disadvantage if they use the boosted dosing most doctors now recommend. Abbott just added another $2500, $5000, or $10,000 per year (wholesale cost) to the price of its competitors' products (depending on how much Norvir needs to be taken to slow the body's destruction of the other drug).

The five-fold price increase could also inhibit the development of new boosted protease inhibitors, now becoming increasingly successful treatment options. "Why bother to invest in these areas if Abbott has effectively priced you out of the market in the U.S.?" one scientist asked.(1)

Community Response

On December 18, 2003, the HIV Medicine Association asked Abbott to "reconsider the recent 500 percent price increase of ritonavir (Norvir®), a drug which as you know is necessary to the success of virtually all protease inhibitor combinations for the treatment of HIV infection. The HIV Medicine Association (HIVMA) represents 2,600 physicians and other health care providers who practice HIV medicine. While we recognize the value of ritonavir, we are alarmed by your decision to raise the cost of protease inhibitor (PI) regimens to the point where many people who need these life-saving drug combinations will struggle to pay for them or will not have access to them at all."(2)

Efforts have started to organize a boycott across all Abbott products. A five-fold drug price increase speaks to everybody, and opens a Pandora's box for a whole new level of corporate abuses. A boycott could be effective if buying from Abbott becomes something to avoid in the medical community, and major hospitals

and other institutions redirect large orders when they have the opportunity, when equally good products are available from competitors. Antitrust avenues are being explored as well (not even Microsoft could raise its competitors' prices); we have heard that state attorney general offices are interested. Also, several ritonavir patents were developed with government support, and under a Federal law known as the Bayh-Dole Act, the government could license a third party to produce the drug if the patent holder fails to make it available on reasonable terms.

And AIDS treatment activists are talking with other groups affected by pharmaceutical-industry abuses.

Comment: Drug Development

In addition to specific remedies, we also need a new look at the big picture of how medicines are developed.

People died in the clinical trials and clinical experience that led to the modern use of boosted protease inhibitors. Patients need options, but now one company wants to take away much of the benefit of what has been learned, in order to increase its market share and profit. Congress has given big pharmaceutical corporations a monopoly on life and death, but this system cannot work unless the power is used with some restraint and respect for public interest.

Americans are told they must suffer exorbitant prices for critical drugs to provide incentive to develop new medicines. But in fact, the industry's record in creating medical breakthroughs is remarkably poor in light of the great advances in biological sciences, and the great resources pharmaceutical companies have at their disposal. The biggest reason, we believe, is one that gets far too little attention -- that the pharmaceutical industry does nothing to develop non-patentable treatments, and very little to develop even proprietary treatments if the rights are unclear or scattered among competitors, who seldom cooperate well. Many if not most of the best medical and scientific leads are off the table entirely under the current system, simply because of ownership and rights issues. Nothing can be done without a clearly visible hook of something to sell -- a way to build a business, perhaps, but not a way to discover new knowledge or create new medicines.

Pharmaceutical companies are marketing organizations, not research organizations. They conduct or fund only a little basic research (much of it for public-relations purposes), and usually farm out clinical research to specialized companies.

And increasingly pharmaceutical companies are lobbying organizations, with more Federal lobbyists, 623, than members of Congress, 535. These lobbyists include 23 former members of Congress, who have special access to their colleagues. The industry spends over $78 million a year on Federal lobbying(3) -- an average of over $145,000 every year to influence each member of Congress, with all this money often targeted to changing just a small number of key votes. Campaign contributions, real and fake "issue" ads, and monies to change public discussion by influencing academics, medical journals, think tanks, physicians, reporters, activists, and other "thought leaders" are not counted in this total.

This is why an unworkable system that threatens everyone's life is so hard to change.

Meanwhile, government, university, non-profit, and public/private groups sometimes develop new drugs (a recent example is the emergency contraceptive, Plan B). But they have been discouraged from doing so by the ideology that this is industry's job -- even while "open source" development in other fields is showing new ways to organize the work of thousands of individuals and teams around the world to create and run large projects successfully.

Pharmaceutical pricing has become a serious issue everywhere in the world (even where there are price controls -- which have worked less well for new drugs

because there is no baseline price, and in any event are under attack by the U.S. government). A five-fold, out-of-the-blue price increase sets a precedent that can hurt anyone. And it moves us further toward a world where the big advances of 21st-century medicine for cancer, Alzheimer's, autoimmune, infectious, and other diseases will routinely be reserved for rich or well-insured minority, while others live or die without them.

The first step toward a better way is to open drug development to a variety of teams, structures, and institutions, not just one. What big pharma can do, and do well, is to bring together the loose ends left by others to accomplish the critically important and intensely political task of getting proprietary drugs into rich or well-insured bodies. Today's pharmaceutical industry can make a better Viagra. But will not develop medicines for diseases of poor countries -- or non-proprietary treatments for anyone, even when they are the best at any price.

For More Information, and How to Help

A place to start is the AIDS Treatment Activist Coalition (ATAC). It has posted materials on the Norvir price increase on its site: http://www.atac-usa.org/

Treatment activists who join ATAC can participate in ongoing discussions on the Norvir price increase, ADAP funding, drug development options, prison health care, and other issues.

References

(1) Unnamed pharmaceutical-company scientist quoted by Keith Alcorn of AIDSMAP, in "Ritonavir price increased: What are the consequences in 2004?" at:
http://www.aidsmap.com/news/newsdisplay2.asp?newsId=2466
(follow the link to Part 2).

(2) A press release and the letter to Abbott from the HIV Medical Association are at: http://www.hivma.org

(3) *America's Other Drug Problem: A Briefing Book on the Rx Drug Debate*, prepared by Public Citizen's Congress Watch, at: http://www.citizen.org/rxfacts

ADAP Washington Visit Feb. 23-25; Scholarship Deadline January 16

As *AIDS Treatment News* went to press we received the following notice from Save ADAP, of the AIDS Treatment Activist Coalition, about an effort to prevent thousands of Americans from being denied HIV treatment solely due to lack of funding. Because a scholarship deadline is next week, we included the information here.

"Save ADAP members from around the country will be visiting our nation's policy makers on February 23-25, 2004 in Washington D.C. to ask Congress for an Emergency Supplemental funding for the crumbling AIDS Drug Assistance Program (ADAP). We are inviting other people living with HIV/AIDS and service providers to join us. Save ADAP is providing 50 full scholarships for people who cannot afford to pay for the trip themselves. Priority will be given to ADAP clients, people on ADAP waiting lists, women, people of color, PWA/HIVs, and frontline service providers living in one of the following ADAP crisis states (Alabama, Alaska, Arkansas, Colorado, Idaho, Indiana, Kentucky, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, South Dakota, Texas, Washington, West Virginia, Wyoming.)

"The scholarship will cover round-trip travel, hotel, and a per-diem for the entire trip. There will be a half-day orientation on Feb. 23rd, followed by visits to both of your U.S. Senators and your House Representative on the two remaining days.

Deadline for applications is Friday, January 16, 2004. Please send the following information to TheAccessProject@aol.com or fax it to 212-260-8869. For questions, please contact Lei Chou at the AIDS Treatment Data Network 212-260-8868 x.21

Name:
Address:
Phone:
e-mail:
Race/Gender:
ADAP client? Y/N
On an ADAP Waiting list? Y/N
HIV Service Provider? Y/N
If yes, what is your job?
Do you need a Scholarship? Y/N

Background:

"In 2003, ADAP served over 90,000 Americans living with HIV disease. This important program has been under funded for the last four years. Congress appropriated a $35 million increase for fiscal year

2004, but this amount falls far short of the $215 million needed to keep pace with the growing demand. This is a critical turning point for the program, starting a new fiscal year with a $180 million budget shortfall, the largest ever, representing roughly 1/5 of the entire budget. As we are nearing the end of the current ADAP fiscal year (3/31/2004), there are already over 700 people on waiting lists across ten states, with another six implementing program cut backs and access restrictions. To ensure current ADAP clients coverage, close to half of the ADAPs around the country will be starting their new fiscal year with their doors closed to new clients.

"In order to prevent the further collapse of ADAP, we are asking Congress and the Administration to provide an Emergency Supplemental funding of $180 million dollars for ADAP for the up coming fiscal year. To this end, Save ADAP is conducting a national grassroots campaign to take the message to our representatives in Washington D.C. Save ADAP members from around the country will be visiting Congressional offices on February 24th and 25th to educate the law makers on the importance of ADAP, and to warn against the dire consequences of underfunding this program. Please join us in this effort to Save ADAP. Please contact Lei Chou at TheAccessProject@aol.com or 212-20-8868 x21 if you want to participate in this event."

For more information about Save ADAP, see:
http://www.atac-usa.org/adap.html

African-Americans and AIDS Conference, Philadelphia, Feb. 23-24

The 2004 National Conference on African-Americans and AIDS -- "a national forum on HIV/AIDS for health professionals who provide care for African-Americans" -- will take place in Philadelphia, February 23 and 24, at the Wyndham Franklin Plaza Hotel.

This year for the first time the conference will have a separate track on advanced HIV management, separated from the basic track.

Conference admission is $100 (which includes both days, continental breakfast, box lunches on both days, and the reception), through February 10. After February 10, or at the door, this price goes up to $135. If you want to stay at the hotel, special conference rates are available.

Program Highlights -- Day 1

* Elaine M. Daniels, M.D., Ph.D.: Epidemiology of HIV in the United States
* Beny J. Primm, M.D.: Introduction of guest speakers
* Danny Glover: Special guest speaker
* Victoria A. Cargill, M.D., M.S.C.E.: Minority Population Research Initiatives
* Mary Lawrence-Hicks, N.P.: HIV Complementary Therapy and Support Care
* Cleo Manago: Protective Factors and Policies
* Working lunch on African-American women, and new activism
* Valerie E. Stone, M.D., M.P.H.: Clinical Management Strategies
* Glenn Treisman, M.D., Ph.D.: Psychiatric Co-Morbidities in the HIV-Infected Patient
* Marc Ghany, M.D.: Hepatitis and HIV Co-Infection, Clinical Management, New Strategies
* Wilbert Jordan, M.D.: Working Specialized Clinic Models
* Henry Francis, M.D.: Legal and Illegal Drug Use
* Evening reception

Program Highlights, Day 2

* Phill Wilson: New Directions in HIV/AIDS Policy
* Jonathan Zenilman, M.D., and Celia Maxwell, M.D.: Men, Women, and STDs
* Jocelyn Elders, M.D., Special guest speaker
* Robert Fullilove III, Ed.D.: The Modern Diaspora from Africa and the Caribbean and Cultural Fluency
* Jean R. Anderson, M.D.: Clinical Management of HIV in Women
* Working lunch panel including Wilbert Jordan, M.D., Keith Cylar, and Darrell P. Wheeler, Ph.D.
* Wilbert Jordan, M.D.: Focused Intervention: Novel Approaches to Outreach
* George W. Roberts, Ph.D.: HIV prevention for African-Americans
* Darrell P. Wheeler, Ph.D.: Special Research Involving Black, HIV-Infected Gay, Bisexual, SGL, Transgender, and Heterosexual MSM
* Keith Cylar, Special Needs of the HIV-Infected Homeless

For more information, see:
http://www.minority-healthcare.com.

AIDS Treatment News Will Publish Online, Print 12 Issues a Year

Starting in January 2004, *AIDS Treatment*

News is moving to a system of publishing drafts or preprints of articles online as news happens, then publishing these stories monthly in the print edition. Since the online preprints may change as necessary, the printed article will be the official version.

The print edition will continue to be published as usual. Subscribers will see no difference, and do not need to take any action as a result of this change.

When the new Web site is ready, it will be available at http://www.aidsnews.org.

Buyers' Club List, December 2002

AIDS Treatment News publishes a buyers' club list each December. For a short overview and introduction to the meaning, history, and services of these organizations, see *AIDS Treatment News* #309, December 18, 1998.

All the organizations listed below are nonprofit. Most can provide products by mail order. Most have fact sheets or other information, and some have a nutritionist or other expert available at certain times to answer questions. Some offer financial assistance with purchases if necessary. Most are open to the public, but some require membership. Call ahead for current information.

Arizona

Body Positive's Vitamin and Herb Shop
1144 E. McDowell Rd, Suite 200
Phoenix AZ 85004
602-307-5330x2239
http://www.phoenixbodypositive.org/vitamin/index.htm

Travis Wright Memorial Buyers' Club
Southern Arizona AIDS Foundation
http://www.saaf.org/
wellness@saaf.org
375 S. Euclid Ave
Tucson AZ 85719
800-771-9054 or 520-628-7223
fax: 520-628-6222; TTY: 800-367-8937

California

Rainbow Grocery Cooperative (20% PWA discount on vitamins, 10% on groceries, with the Helping Hand card)
http://www.rainbowgrocery.coop/ (or http://www.rainbowgrocery.org/)
vitamins@rainbowgrocery.org
1745 Folsom St.
San Francisco CA 94103
415-863-0620

Colorado

Denver Buyers' Club
pwacolo@aol.com
1290 Williams St.
Mailing address: P.O. Box 300339, Denver CO 80203-0339
303-329-9379x108, fax: 303-329-9381
Bilingual Spanish/English TTY: through operator

District of Columbia

Carl Vogel Center
cvchiv@carlvogelcenter.org
1012 14th St. NW, Suite 700, Washington DC 20005
202-638-0750, fax: 202-638-0749

Membership: annual cost $25 (includes a BIA test, reduced prices for massage and acupuncture, an educational symposium, a newsletter, and reduced prices for supplements).

The Carl Vogel Center now offers mental health services and treatment education.

Georgia

AIDS Treatment Initiatives
info@aidstreatment.org
139 Ralph McGill Blvd. NE Suite 305
Atlanta GA 30308-3311
888-874-4845 or 404-659-2437
fax: 404-450-9412

Massachusetts

Treatment Information Network's Boston Buyers' Club
http://www.bostonbuyersclub.com/
info@bostonbuyersclub.com
Boston Living Center, 29 Stanhope St., 3rd Floor
Boston MA 02116
800-435-5586, or 617-266-2223
fax: 617-450-9412

New York

DAAIR (Direct Access Alternative Information Resources)
http://www.daair.org/ (see note below)